TREATMENT AUTHORIZATION

AUT

U.S. HealthWorks MEDICAL GROUP
A Dignity Health Member

We are authorizing the below listed U.S. HealthWorks(s) to provide treatment to our employees. By doing so, we acknowledge that if the claim is denied by our insurance carrier, we will notify USHW of the denial and will be responsible for payment for all services rendered and any medically-necessary items dispensed.

U.S. HEALTHWORKS MEDICAL GROUP LOCATED AT:

ADDRESS: NATIONAL CITY - 102 MILE OF CARS WAY, NATIONAL CITY, CA 91950

PHONE: (619) 474-9211 FAX: (619) 474-2000

EMPLOYER

EMPLOYER NAME: NAVY REGION SOUTHWEST EMPLOYER# (if applicable): 199473

EMPLOYER ADDRESS: 2375 RECREATION WAY, BLDG 3210, SAN DIEGO, CA 92136 PRIMARY CONTACT NAME: Cristina Quintero

PHONE: 619 556-8370 AFTER HRS / CELL PHONE:

FAX: 619 556-9537 EMAIL: cristina.quintero@navy.mil

EMPLOYEE DETAILS

PATIENT NAME: DATE: TIME: AM / PM

DEPARTMENT: Child & Youth Programs POSITION: Child & Youth Program Assistant

DOES EMPLOYEE WORK FOR A TEMP/LEASING COMPANY? ○ YES ◉ NO NAME OF TEMP AGENCY:

AUTHORIZED BY: NAME (print): Kemmiel Snowden PHONE: (619) 556-8262

TITLE: NAF Human Resources Assistant AFTER HRS / CELL PHONE:

SIGNATURE ( ) VERBAL AUTHORIZATION

INSURANCE

INSURANCE COMPANY NAME

CLAIMS ADDRESS:

PHONE: EFFECTIVE DATE:

POLICY #: EXPIRATION DATE:

SERVICES

○ INJURY: DATE OF INJURY: LAST WORKED:

INJURED BODY PART: CLAIM #:

○ RETURN-TO-WORK EVALUATION:

◉ PHYSICAL EXAM TYPE: PE-BASIC (w/ client form) + PAT + AUDIOGRAM PROTOCOL #:

○ DRUG/ALCOHOL TEST - specify type and reason/purpose below: PROTOCOL #:

TYPE:

❑ DOT DRUG TEST ❑ DOT BREATH ALCOHOL TEST
Agency (required): _____

❑ NON-DOT DRUG TEST ❑ NON-DOT BREATH ALCOHOL TEST

❑ INSTANT DRUG TEST

REASON/PURPOSE:

❑ PRE-EMPLOYMENT ❑ RANDOM

❑ REASONABLE SUSPICION ❑ POST-ACCIDENT

❑ RETURN TO DUTY ❑ FOLLOW UP

❑ POST-INJURY

Perform test before: Date: _____ Time: _____ AM / PM

*** PICTURE ID REQUIRED FOR DRUG TEST**